

Patient Safety Program

PARTNERING FOR A NEW LEVEL OF CARE



SUMMER 2011

A QUARTERLY NEWSLETTER TO HELP THE MILITARY HEALTH SYSTEM IMPROVE PATIENT SAFETY

NPSF 2011 CONGRESS OVERVIEW



DoD PSP booth, 2011 NPSF Congress Exhibition Hall

The National Patient Safety Foundation's (NPSF) 13th Annual Congress was held May 25–27, 2011, at the Gaylord Convention Center, National Harbor, Maryland. This is the only healthcare conference in existence in which the sole focus is on the subject of patient safety matters. NPSF is the first professional organization with patient safety as its primary purpose, where patient safety is a professional discipline. The theme for this year's congress was "It's in Our Hands: Sharing Accountability and Responsibility in Pursuit of Patient Safety."

The congress offered myriad resources, usable tools, and evidence-based solutions to enable healthcare providers and patients to learn how they can work together to share accountability and actively maintain a culture of safety. In addition to 70 participants in the exhibit hall, the congress included a learning and simulation center.

The breakout sessions were organized in six theme tracks:

- Assuring Accountability and Mindfulness across the Continuum of Care
- Building Processes to Drive Personal and Collective Accountability
- Healthcare Reform and Accountability
- Innovation and Hot Topics
- Shared Decision Making to Promote Accountability between Patients and Providers
- Teamwork and Communication for Enhanced Accountability.

Members of the Lucian Leape Institute held a town hall meeting in which they shared their ideas on the various aspects of patient safety: healthcare reform's impact on the progress of patient safety and what needs to be done to stimulate "real, meaningful change." Lucian Leape noted that "We have made progress. You are 1,000 points of light, but there are 4–5,000 dark places still. It used to be 'what we should do,' now it's 'how we should do it, what can we do to move ahead.'"

Friday's plenary session, "Healthcare Simulation, Live on Stage!" included emergent scenarios, which demonstrate that "practice really can make perfect." As Paul Preston, MD, (Department of Anesthesia, San Francisco Medical Center and Physician Safety Educator, The Permanente Medical Group) stated, "If we practice, rehearse, and debrief, we are inherently safer."

The impact of accountability and responsibility in healthcare today was dramatically interpreted by the National Symphony Orchestra, conducted by Roger Nierenberg, creator of the Music Paradigm, in which a symphony orchestra is presented as a metaphor for an organization, addressing and examining its unique challenges, initiatives, goals, and more.

Save the date for the 14th Annual Patient Safety Congress, to be hosted May 23–25, 2012, at the Gaylord National Hotel in National Harbor, Maryland. Visit <http://npsfcongress.org> for details and updates.

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ONE MISSION, ONE TEAM

Director's Corner

The Patient Safety Program was privileged and delighted to have been part of two very exciting events — the Air Force Medical Operations Agency's (AFMOA) Quality System Program Assessment Review (QSPAR) in San Antonio, Texas and the National Patient Safety Foundation's (NPSF) 13th Annual Congress, which was held at the Gaylord National Convention and Resort Center in National Harbor, Maryland. It is vital to our success as the representatives of patient safety that we keep our members continually updated on improvements, initiatives, and DoD-related quality issues, so that we may continue to provide the highest-quality level of care to the patients that we serve.

As a keynote speaker, I was honored to address the QSPAR attendees on the subject of patient safety history, including technologies such as high reliability, data analysis, and the Patient Safety Reporting System (PSR), which have enabled the constant improvement and evolution of the patient safety program. The NPSF Congress is an annual opportunity to learn from and exchange ideas with patient safety experts and practitioners from all over the world. It is the only existing conference that focuses exclusively on patient safety. Thirty education sessions, designed by subject matter experts, offered usable tools, resources, and evidence-based solutions for real-life patient safety matters.

The Patient Safety Reporting System (PSR) will be completely deployed service-wide by June 30, 2011. From November 2010 through June 2011, PSR training will have been completed worldwide at 171 MHS medical and dental facilities. The overall satisfaction rate is an outstanding 98%. The Basic Patient Safety Manager course is continually updated to reflect current patient safety developments and will be offered once more in FY2011, September 12–16.

I leave you with the question I posed to the QSPAR attendees: "Are you habitually excellent?" This is a question we should ask ourselves daily and, every time, the answer should be a resounding "Yes!" With this as a guide and a daily goal, we are best equipped and ready to provide the most excellent treatment to the patients entrusted to our care. I wish you all a safe, healthy, and happy summer.



Donald W. Robinson, LTC, MC
Director, DoD Patient Safety Program

PARTNERSHIP FOR PATIENTS

Health and Human Services (HHS) Secretary Kathleen Sebelius, joined by leaders of major hospitals, employers, health plans, physicians, nurses, and patient advocates, announced the Partnership for Patients, a new national partnership that will help save 60,000 lives by stopping millions of preventable injuries and complications in patient care over the next 3 years. More than 500 hospitals, physicians and nurses groups, consumer groups, and employers have pledged their commitment to the new initiative.

"Americans go the hospital to get well, but millions of patients are injured because of preventable complications and accidents," said Secretary Sebelius. "Working closely with hospitals, doctors, nurses, patients, families, and employers, we will support efforts to help keep patients safe, improve care, and reduce costs. Working together, we can help eliminate preventable harm to patients."

Leaders from across the nation have pledged their commitment. To launch this initiative, HHS announced it would invest up to \$1 billion in federal funding, made available under the Affordable Care Act. The funding will be invested in reforms that help achieve two shared goals:

- **Keep hospital patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. This translates to approximately 1.8 million fewer injuries to patients, with more than 60,000 lives saved over the next 3 years.

- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to

another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal means that 1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

The Partnership will target all forms of harm to patients but will start by asking hospitals to focus on nine types of medical errors and complications where the potential for dramatic reductions in harm rates has been demonstrated by pioneering hospitals and systems across the country.

HHS has committed \$500 million to community-based organizations partnering with eligible hospitals to help patients safely transition between settings of care. Community-based organizations and acute care hospitals that partner with community-based organizations can begin submitting applications for this funding. Applications are being accepted on a rolling basis. Awards will be made on an ongoing basis as funding permits.

For more information about the Partnership for Patients, visit www.HealthCare.gov/center/programs/partnership. For a fact sheet on this announcement, visit www.HealthCare.gov/news/factsheets/partnership04122011a.html.

For more information about the Community-based Care Transitions Program funding opportunity, visit www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313. Courtesy of the U.S. Department of Health and Human Services

WHAT YOUR DOD PSP CAN DO FOR YOU

Mandated under the Floyd D. Spence National Defense Authorization Act of 2001, the DoD PSP helps ensure the safe delivery of health care to the 9.6 million patients in the Military Health System (MHS). The culture of safety is fostered through promoting trust and transparency to empower everyone to administer safe and reliable care to every patient.

The DoD PSP guiding principles include:

- Encouraging a systems approach across the services to create a safer patient environment
- Promoting innovation and creativity
- Engaging leadership
- Fostering a culture of trust and transparency through communication, coordination, and teamwork
- Embracing national initiatives deemed beneficial to the MHS — such as Patient Safety Awareness Week, which is spearheaded by the National Patient Safety Foundation.

The program provides products, services, and educational and training resources aimed at achieving the goal of zero preventable harm. Numerous resources are available and are referred to here as the “Sweet Sixteen.” The full list of offerings may be viewed on the PSP Web site (<http://health.mil/dodpatientsafety>).

If you are looking for general information on available resources and an opportunity to advance your knowledge as well as link to resources:

- Patient Safety Program (PSP) Web site
- Patient Safety Learning Center (PSLC).

If you are looking for patient safety training and education programs:

- Patient safety pathways to success — TeamSTEPPS® Trainings —

a systematic approach to change how we practice to deliver safe care

- Patient safety pathways to success — The Basic Patient Managers Course (BPSM) and TapROOT®
- Team Resource Centers (TRCs)
- Toolkits
- Patient safety learning circles and workshops.

If you are looking for a tool to help engage your patients and their families:

- TEAM UP — the starting point for engaging patients as part of the care team, including a brochure that guides them on how to actively participate in their care.

If you are looking for tools that will help you with assessment:

- Culture survey
- Team Effectiveness Accelerator (TEA).

If you want information on Probability Risk Assessment:

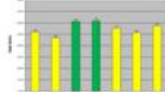
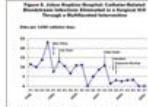
- Root Cause Analyses (RCAs), Failure Modes and Effects Analysis (FMEA).

If you want information on Patient Safety Reporting:

- PSR Reporting.

If you are looking for PSP publications:

- Quarterly newsletters
- Monthly eBulletin and learning updates
- Alerts and advisories and medication safety notices
- Focused Reviews and summaries.

PSP Website 	PSLC 	BPSM and TapRoot 	TeamSTEPPS Trainings 
Toolkits 	TRCs 	PSP Learning Circles and Workshops 	TEAM UP 
TEA 	Culture Survey 	RCA, FMEA 	PSR Reporting 
PSP Newsletter 	PSP eBulletin and Learning Update 	Alerts and Advisories 	Focus Reviews and Summaries 

The PSLC is another tool offering general information on available resources, such as:

- DoD patient safety information
- Online discussion forums
- Lessons learned from RCAs
- Calendar of learning events and activities
- Virtual meeting tools
- Training materials, toolkits, and resources
- Specialty communities.

The DoD Tri-Service Survey on Patient Safety, sponsored and funded by TRICARE Management Activity (TMA), is an anonymous Web survey designed to assess staff opinions about issues related to patient safety in the MHS. All staff working in Army, Navy, and Air Force Military Treatment Facilities (MTFs) and dental treatment facilities world-wide were asked to complete this survey. This survey was first conducted in late 2005/early 2006 and was conducted for a second time in Spring 2008.

The purpose of the survey is to:

- Understand the current status of patient safety culture in MHS facilities
- Raise staff awareness about patient safety issues
- Assess trends in staff attitudes
- Provide an action plan to continue to provide a safer care environment in all MHS settings.

The existing resources available around the safety culture survey are:

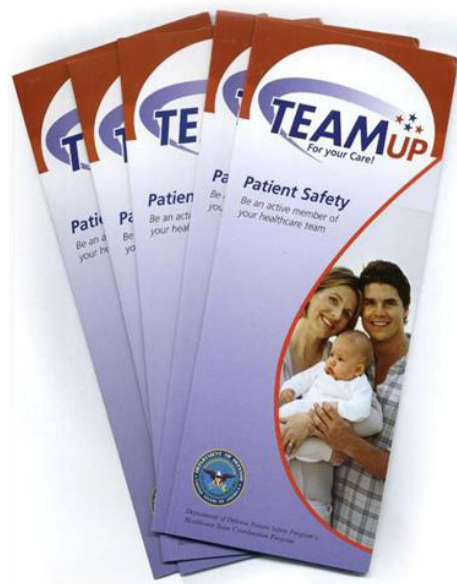
- Service, MTF, and facility-level reports and data (contact service headquarters to access).
- DoD-level survey briefings and reports – includes comparisons across services and with the civilian environment, trending, how various staff types responded to the survey, and how various work areas responded to the survey.
- Improvement guide profiling select MTFs on how they achieved high scores, developed with the intent to share tips and ideas from selected facilities who scored high on the survey.
- Action planning resource reference list – links to the Agency for Healthcare Research and Quality's references and resources on how to interpret and take action on various areas measured by the culture survey.

Information shared through PSR, FMEAs, and RCAs formulate in-depth analysis of focused areas – results of those analyses are published as *Focused Reviews*, which help inform those directly engaged in providing healthcare of trends, notable causal factors, and useful lessons learned from events seen in facilities and provide some of the latest research and innovations relative to the topic.

Alerts and advisories

are brief, often time-sensitive reports targeted at error-prone patient safety issues in which all targeted providers and staff should receive timely notification. These are based on emerging issues identified by voluntary reports in PSR or sentinel event (SE) notifications. Alerts and advisories are posted on the PSLC and distributed through service headquarters' communication channels. Nonspecific DoD issues or alert/advisory issues by other entities are posted on the PSLC as applicable. These issues may involve anything used in or on patients (e.g., equipment, devices, etc.) that may place them at increased risk. These notices provide background, general information, and recommendations for addressing the patient safety issue.

A learning circle exploring these components in depth was held in 2011. Contact the PSP staff to receive the download link. We can partner with you to help you step into action!



Engaging, Educating and Equipping the entire patient-care team to institutionalize evidence-based safe practices by:

**Fostering a
culture of
safety**

**Engaging
leadership**

**Providing
solutions**

**Training
patient safety
champions**

**Partnering &
collaborating
with patient
safety leaders**

2011 AIR FORCE QSPAR SYMPOSIUM



QSPAR 2011 Symposium Risk Management presentation

Air Force Medical Operations Agency's (AFMOA) Clinical Quality Division hosted its annual Clinical Quality Conference, known as QSPAR (Quality System Program Assessment Review). The conference is held in San Antonio, Texas and is directed by the Office of the Surgeon General and AFMOA. It is critical in keeping members updated on AF and DoD pertinent issues, directives, and presidential initiatives. Other purposes of the conference are to enable participants to understand key quality issues related to AF Quality, DoD patient safety reporting, credentials and privileging challenges, risk management malpractice and adverse actions issues, sentinel events, legal aspects, standards of care, and disclosure.

Conference attendees are representatives from all 75 AF Medical Treatment Facilities, such as those employed as Chief of the Medical Staff, Quality Management and Performance Improvement Managers, Credentials and Privileging Managers, Risk Management, and Patient Safety personnel. Other attendees included MAJCOM Commanders, consultants, and credential representatives from the Air National Guard and AF Reserve.

The conference offered plenary and breakout sessions that highlighted reliability in the AFMS quality arena, its importance, how we are doing, getting the basics right, and maintaining reliability. It also offered information technology on-the-spot, systems support, computer instruction on the use of MedFACTS self-inspection tool, CCQAS (credentials database), and on-the-spot HIPAA consultants to answer questions and clarify privacy banner statements.

Opening day of the conference kicked off with briefings from Air Force leaders Major General Byron Hepburn and Brigadier General Mark Ediger, keynote speaker Army LTC Donald Robinson, Director of the DoD Patient Safety Program, as well as subject matter experts Mr. Joe Procaccino, Legal Advisor to the Surgeon General, and Barbara Moidel, Special Assistant to Healthcare Resolutions.

Major General Byron Hepburn, briefed on the AF Medical Service Mission, its framework for success, initiatives such as Patient Centered Medical Home implementation, Status of Healthcare in the U.S., and Partnerships for Patients. He also discussed social media and technology initiatives and closed with a foot stomp on the importance of leadership in quality and patient safety.

Brigadier General Ediger briefed on the status of AFMOA, its strategic initiatives, Quality and Patient Safety interest, and clinical currency platforms, to name a few. LTC Robinson spoke on the History of Patient Safety and its evolution, high reliability, data analysis, and patient safety reporting. He left the audience with the question and food for thought, "Are You Habitually Excellent?" Mr. Procaccino captivated the audience by providing legal examples and lessons learned from case studies. Ms. Moidel spoke on the importance and correct ways to resolve issues related to adverse incidents, and Col Houge, AFMOA Clinical Quality Division, closed the day with AFMOA/Quality's current state related to clinical quality, performance improvement, risk management, patient safety, credentials, and privileging.

PSR UPDATE

The PSR, a web-based tool that has replaced paper-based reporting, will be completely deployed across the Military Health System (MHS) by June 30, 2011. When fully deployed, PSR will enable the MHS to improve the safety for medical beneficiaries worldwide. As a result, the Army, Navy, and Air Force will use a single, secure system that allows each member of the DoD healthcare team to anonymously report patient safety events or potentially unsafe conditions via the Web. The application delivers standardized electronic reporting of patient safety events and can be used to track and trend medical adverse events. The PSR data will be used locally and at the DoD level to help determine why an event occurred and what steps can be taken to prevent its reoccurrence.

The DoD was successful in the limited deployment of PSR to selected military treatment facilities and moved to full deployment on November 1, 2010. PSR will have completed worldwide training at 171 MHS medical and dental treatment facilities between November 2010 – June 2011. The overall satisfaction level from users receiving both on-site instructor-led training and virtual instruction is 98%.

The goal for PSR is to see increased event reporting due to its ease and anonymity. Increased data will allow the DoD Patient Safety Program (PSP) to disseminate information throughout the MHS with the intent of reducing the severity and frequency of patient safety events. Please stay tuned for further updates or contact the DoD PSP if you have further questions.

BPSM COURSE UPDATE

As a direct link to the front lines of patient care, Patient Safety Managers (PSMs) are champions of patient safety by providing leadership at the local level, bringing safety-related issues to the forefront, sharing innovative ideas on how to address these issues, and helping to implement changes. The Patient Safety Program (PSP) is focused on developing leadership at the PSM level through an educational curriculum designed for new PSMs, orienting them to the position and sharing tools for success.

The Basic Patient Safety Manager (BPSM) Course is a 5-day, instructor-led classroom training program that provides new PSMs throughout the Military Health System (MHS) with the knowledge and skills they need to begin their jobs. The course focuses on four key areas:

- Evidence-based practice and standards
- Leadership and change management
- Quality management and process improvement
- Identifying and mitigating risk.

Throughout the course, new PSMs have the opportunity to network with experienced healthcare professionals and meet with their service representatives, as well as plan how they will put their knowledge into practice when they return to their facilities through the completion of roadmap activities. The course ends with training on the TapRoot® methodology and software, which PSMs will use to conduct root cause analyses when they return to their facilities.

BPSM course content is continually updated to reflect the latest developments in patient safety. For example, the lesson on "Regulation, Accreditation, and Professional Standards" was recently revised to incorporate 2011 accreditation standards and the introduction of the revised DoD Instruction 6025.13. Other planned revisions to the upcoming course content include updating lessons on "Measurement: Data Collection, Analysis, and Feedback" and "Reporting," to reflect the release of the Patient Safety Reporting System.

The BPSM course is supported by follow-up coaching and evaluation at 3, 6, and 12 months post-course; coaches are currently engaged

in conversations with participants who attended the sessions in April and May 2010. Learners are coached and provided with performance support to identify strategies for overcoming barriers, reinforce BPSM course content, and how to direct participants to patient safety resources to facilitate success in their roles. Regarding the sessions, participants have said, "the calls allow me to evaluate myself and my achievements," and "the calls forced me to stop and take a look at my goals and how I am progressing." One learner even reported that the coaches "have given me a path to walk on."

The BPSM course will be offered once more in fiscal year 2011, with a fall session from September 12 – 16, 2011. Course dates for 2012 have not yet been determined. Participants are selected to attend by representatives from each of the services, and registration is limited to 30 learners in total. For additional information on the course and for questions regarding eligibility, contact your service representative:

- Army contact: Dana Rocha (dana.rocha@us.army.mil)
- Navy contact: Christine Winslow (christine.winslow@med.navy.mil)
- Air Force contact: Cynthia Lightner (cynthia.lightner.ctr@us.af.mil).

UPCOMING EVENTS

June 2011

- **30th:** Department of Defense Patient Safety Workshops: Professional Conduct Toolkit Workshop Spring Series Part IV: Techniques for Maintaining Resilience When Working with High Conflict People.

July 2011

- **27th:** National Patient Safety Foundation (NPSF) Professional Learning Series Webcast: "Quality, Safety, and Reliability: Engaging Physicians and Influencing Culture Change."

August 2011

- **10th:** Agency for Healthcare Research & Quality (AHRQ) TeamSTEPPS Webinar 21: Measuring the Impact of the National Implementation of TeamSTEPPS Project. 12:00 pm – 1:30 pm EST.
- **17th:** National Patient Safety Foundation (NPSF) Professional Learning Series Webcast: "A Multidisciplinary Approach to Falls Prevention."
- **18th:** Department of Defense Patient Safety Program Commander's Forum.

PATIENT SAFETY PROGRAM NEWSLETTER

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